

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

**=63-022903**

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 333 Primary Registration District No. 3074 Registrar's No. 126

**FILED JUN 3 1963**

1. PLACE OF DEATH a. COUNTY <u>SCOTT</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>MISSISSIPPI</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>SIKESTON</u>		c. CITY OR TOWN <u>EAST PRAIRIE</u>	
Length of stay in 1b <u>2 1/2</u> days		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>MO. DELTA COMMUNITY HOSP.</u>		d. STREET ADDRESS (If outside, give location) <u>RT. # 2</u>	
Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			

3. NAME OF DECEASED (Type or print)		First Middle Last <u>MARY ALICE STERLING</u>		4. DATE OF DEATH Month Day Year <u>5-19-63</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>10-6-1919</u>	9. AGE (last birthday) <u>43</u>	IF UNDER 1 YEAR Months <u>7</u> Days <u>13</u> Hours <u>13</u> Min. <u>13</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DOMESTIC</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ballard Co., Ky.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Thomas H. Stone</u>		13b. MOTHER'S MAIDEN NAME <u>Alice Hess</u>		14. NAME OF HUSBAND OR WIFE <u>Landon Sterling</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>[REDACTED]</u>		17. INFORMANT Address <u>Landon Sterling, East Prairie, Mo.</u>	

18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> DUE TO (b) <u>Renal failure.</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u> <u>48 hrs.</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Multiple renal calculi.</u>		PART III. If deceased was female was there a pregnancy in last 90 days <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
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20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year			
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE
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21. I attended the deceased from <u>5/17/63</u> to <u>5-19-63</u> and last saw her alive on <u>5-19-63</u> Death occurred at <u>2:05 P.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE <u>William J. Shannon, MD</u> (Degree or title)	22b. ADDRESS <u>1022 N. Main, Sikeston, Mo.</u>	22c. DATE SIGNED <u>5/20/63.</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>5-21-1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Dogwood Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Mississippi Co., Missouri</u>
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24. FUNERAL DIRECTOR <u>Travis Shelby, East Prairie, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>May 27-1963</u>	26. REGISTRAR'S SIGNATURE <u>Jeanette Waldman</u>
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(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK  
OR  
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS 300  
Rev. 4/59  
1007  
20670  
3  
4 1  
5 1  
6  
7 1  
8 2  
9593X  
10  
11  
12 1-0  
13 2-0

JUN 18 1963

AUG 13 1963

SEP 10 1963

SEP 17 1963

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*Travis Shelby*

Licensed Embalmer No.

*4940*

P. O. Address

*East Prairie, Mo*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.

*Permit received May 19-1963*